DOCKET NUMBER 32-4

G. The terms "REFER TO" or "RELATE TO" as used herein shall mean supports, describes, alludes to, comments on, discusses, shows, discloses, explains, mentions, analyzes, indicates, regards, respects, affects, concerns, touches on, pertains to, compares, balances, links, suggests, constitutes, comprises, evidences, sets forth, summarizes or characterizes, either directly or indirectly, in whole or in part.

H. The singular shall be interchangeable with the plural, the masculine, feminine, and neuter shall be interchangeable, and the terms "and" and "or" shall be both conjunctive and disjunctive.

2. It is not intended that this request for DOCUMENTS require the disclosure of any DOCUMENTS which YOU claim are protected against disclosure as "work product" or "privileged," although plaintiff reserves the right to move for disclosure. For any DOCUMENT withheld on such grounds, please provided a written response with the following information:

A. A description of the DOCUMENTS sufficiently particular to identify it and to enable YOU to identify, disclose or produce it in response to an order of the above-entitled court;

B. The nature of the protection claimed;

C. A list of all PERSONS who participated in the preparation of the DOCUMENT;

D. A list of all PERSONS to whom the DOCUMENT was circulated, or its contents communicated.

DOCUMENTS TO BE PRODUCED

1. Copies of any and all DOCUMENTS, for June 30, 2004, to the present, in YOUR possession, custody or control, which REFER or RELATE in any way to YOUR Acct. No. 37287380-4.

2. Copies of any and all DOCUMENTS, for June 30, 2004, to the present, in YOUR possession, custody or control, which REFER or RELATE in any way to YOUR Auto Insurance account of **Francis J. Lopez.**

3. To the extent they are different from those previously requested, copies of any and all DOCUMENTS, for June 30, 2004, to the present, in YOUR possession, custody or control which REFER or RELATE to **Francis J. Lopez.**

4. Copies of any and all DOCUMENTS, for June 30, 2004, to the present, in YOUR possession, custody or control, which REFER or RELATE in any way to records of charges and payments made by **Francis J. Lopez.**

EXHIBIT B

PREPARED: 10/13/05 ACCOUNT BILLING HISTORY PAGE: 1
PROGRAM UT476L DETAILS
OKALOOSA GAS DISTRICT
(7/26/05 TO 10/13/05)

CUSTOMER: 232079 LOPEZ, FRANCIO J
310 SAND MYRTLE TRL
DESTIN FL 303413429

LOCATION: 74786 310 SAND MYRTLE TRL DESTN
BALANCE: .00
CYCLE/ROUTE: 01-13
STATUS: A
BUDGET TRANSACTIONS (*)

DATE	TRANSACTION TYPE	DESCRIPTION	PREVIOUS BALANCE	CURRENT AMOUNT	BILLED CONSUMPTION	TOTAL BILL AMOUNT
9/20/05	PMT			46.38-		
9/23/05	BILL	CYCLE BILL	.00			48.38
	GS	CUSTOMER CHARGE		10.00		
	GS	COST OF GAS CHARGE		21.60	23.03	
	GS	DELIVERY CHARGE		10.04	23.03	
		LATE CHARGE		4.74		
		TOTAL ACTUAL CHGS		48.38		
8/21/05	PMT			47.37-		
8/19/05	BILL	CYCLE BILL	.00			47.37
	GS	CUSTOMER CHARGE		10.00		
	GS	COST OF GAS CHARGE		25.81	27.20	
	GS	DELIVERY CHARGE		11.86	27.20	
		TOTAL ACTUAL CHGS		47.37		
8/08/05	PMT			34.10-		
7/22/05	BILL	CYCLE BILL	.00			34.10
	GS	CUSTOMER CHARGE		10.00		
	GS	COST OF GAS CHARGE		12.29	18.80	
	GS	DELIVERY CHARGE		8.20	18.80	
		LATE CHARGE		3.61		
		TOTAL ACTUAL CHGS		34.10		
7/20/05	PMT			44.33-		
6/21/05	BILL	CYCLE BILL	.00			44.33
	GS	CUSTOMER CHARGE		10.00		
	GS	COST OF GAS CHARGE		15.69	23.92	
	GS	DELIVERY CHARGE		10.43	23.92	
		LATE CHARGE		8.27		
		TOTAL ACTUAL CHGS		44.33		
6/10/05	PMT			83.74-		
5/19/05	BILL	CYCLE BILL	.00			82.74
	GS	CUSTOMER CHARGE		10.00		
	GS	COST OF GAS CHARGE		43.63	66.78	

(7/28/03 TO 10/13/05)

CUSTOMER: 282079 LOPEZ, FRANCIS
LOCATION: 74788 910 SAND MYRTLE TRL

DESTN

TOTALS BY CATEGORY

GS Charges	2997.52
Other Charges	147.14
TOTAL CHARGES	3144.66
TOTAL TRANSFER BALANCE FROM	.00
TOTAL TRANSFER BALANCE TO	.00

CONSUMPTION PARAMETERS FOR GAS SERVICE

EXCEPTION REPORT FLAG	
CONSUMPTION ESTIMATE	.00
DEMAND CONSUMPTION ESTIMATE	.00
AVERAGE CONSUMPTION	3.05
AVERAGE DEMAND CONSUMPTION	.00
TOTAL CONSUMPTION	2399.38
TOTAL DEMAND CONSUMPTION	.00
TOTAL READING DAYS	786

EXHIBIT C

ACORD

EVIDENCE OF PROPERTY INSURANCE

DATE (MM/DD/YY) 10/22/04

THIS IS EVIDENCE THAT INSURANCE AS IDENTIFIED BELOW HAS BEEN ISSUED, IS IN FORCE, AND CONVEYS ALL THE RIGHTS AND PRIVILEGES AFFORDED UNDER THE POLICY.

PRODUCER
PHONE/FAX (A/C, No, Ext): 850-230-0800 850-230-0992

Coastal Community Ins Agency
12139 Panama City Beach Pkwy
Panama City Beach FL 32407
Anthony DuBose

CODE: SUB CODE:

AGENCY CUSTOMER ID #: KELLY-1

COMPANY
Landmark American Ins Co
c/o Roehrig & MacDuff

INSURED

Kelly Plantation Owners Assoc.
34851 Emerald Coast Pkwy # 150
Destin FL 32541

LOAN NUMBER:

POLICY NUMBER: LHQ336763

EFFECTIVE DATE: 07/30/04

EXPIRATION DATE: 07/30/05

CONTINUED UNTIL TERMINATED IF CHECKED: ☐

THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION

LOCATION/DESCRIPTION

001

310 Sand Myrtle Trail
Destin FL 32541

Single Family residence of Frances & Madeline Lopez

COVERAGE INFORMATION

COVERAGE/PERILS/FORMS	AMOUNT OF INSURANCE	DEDUCTIBLE
Flood Coverage as provided in Difference in conditions policy provided for homeonwers of Kelly Plantation Homeowners Association Inc. subject to policy forms, provisions and :lusions Frances & Madeline Lopez Single Family Dwelling 310 Sand Myrtle Trail	250000	25000

REMARKS (Including Special Conditions)

CANCELLATION

THE POLICY IS SUBJECT TO THE PREMIUMS, FORMS, AND RULES IN EFFECT FOR EACH POLICY PERIOD. SHOULD THE POLICY BE TERMINATED, THE COMPANY WILL GIVE THE ADDITIONAL INTEREST IDENTIFIED BELOW 00 DAYS WRITTEN NOTICE, AND WILL SEND NOTIFICATION OF ANY CHANGES TO THE POLICY THAT WOULD AFFECT THAT INTEREST, IN ACCORDANCE WITH THE POLICY PROVISIONS OR AS REQUIRED BY LAW.

ADDITIONAL INTEREST

NAME AND ADDRESS

Frances & Madeline Lopez

310 Sand Myrtle Trail
Destin FL 32541

☐ MORTGAGEE ☐ ADDITIONAL INSURED
☐ LOSS PAYEE ☒ Homeowner

LOAN #

AUTHORIZED REPRESENTATIVE

Anthony DuBose

FROM : FAX NO. :850 269 1034 Aug. 05 2004 10:32AM P1

TO: BETH MARTIN

FROM: FRANCIS LOPEZ

2 PAGES

1. I'M SENDING A CHECK FOR $920.94

2. CHUCK WITH BANK ONE WILL BE CONTACTING YOU FOR PROOF OF INSURANCE

THANK YOU,

FRANCIS LOPEZ
(850) 650-8341

Kelly Plantation Homeowner Association
Master Flood Insurance Policy Renewal Offer

Term of July 30, 2004 to July 30, 2005

Homeowner Information:

Francis and Madeleine Lopez
310 Sand Myrtle Trail
Destin, FL 32541

Phone: 850-650-8341 or 760-214-1955
Fax: 850-650-8341
E Mail medigmail@aol.com

Location of Insured Property: Same as mailing

Flood Zone: __AE_____ Attach elevation certificate if available

Limit Currently Provided: ~~$452,000~~ 250,000

Deductible: $10% of Insured Value ($45,200)

Premium for Term 7-30-04 to 7-30-05 $ ~~1,665.06~~ 920.94

Mortgage Information: Countrywide Home Loans, Inc.
ISAOA ATIMA
P. O. Box 10212
Van Nuys, CA 91410-0212

I hereby elect to purchase the product renewal offered by Landmark American:

Homeowner _____ Date: 8/4/04

I hereby REJECT this offer of coverage and understand no coverage will be in force after July 30th, 2004 under this flood insurance policy. (DIC)

Homeowner _____ Date: _____

EXHIBIT D

Caller Request COPY

Request ID:	213443732	Contract ID:	58449061
Request Type:	Contract Information	Amount:	$0.00
Date Of Request:	11/16/2004	Reason:	
Request Description:	OK TO SERVICE		

Send To Address: PO BOX 219
DESTIN, FL 32540-0219

Work Order:

Line Item:

Dispatch ID:

Caller	Phone #	Role
MADELINE LOPEZ	(850)650-8341	Buyer

EXHIBIT E

Cards
American Express Cards
777 American Expressway
Ft. Lauderdale, FL 33337

October 19, 2005

L. Scott Keehn
L. Scott Keehn
530 B Street Suite 2400
San Diego, CA 92101

RE: Francis J. Lopez
Our File No: 05285GIM3263415

Dear Sir / Madam:

Please be advised that American Express Travel Related Services, Company, Inc. / American Express Centurion Bank is unable to comply with the above referenced subpoena request for the following reason(s):

• American Express Travel Related Services Company, Inc. does not have records responsive to the subpoena request

If we can be of further assistance please do not hesitate to contact us.

Sincerely,

Linda Y Salas, Subpoena Correspondent
Assistant to the Custodian of Records
(954) 503-7001 ext. 65943
INSFLTR

EXHIBIT F

CORPORATION SERVICE COMPANY®

Return of Service of Process

SLM
Transmittal Number: 4188614

Return to Sender Information:

L Scott Keehn
Robbins & Keehn, APC
530 B Street
Suite 2400
San Diego, CA 92101

Date:	10/04/2005
Entity:	Chevron Texaco
Title of Action:	Francis J. Lopez vs. Chevron Texaco
Court:	U.S. Bankruptcy Court Southern District, California
Case Number:	05-05926-PB7

Service of Process has been received from you on behalf of one of the defendants named in the above action.

The service of process received from you is being returned. We cannot receive this service as registered agent due to the reason(s) listed below.

Because two different companies can have very similar names, the name of the company for whom service is directed MUST BE IDENTICAL to the company name on file with the Secretary of State, or other appropriate state agency.

Our client records are confidential. We do not release any information on our clients, agent representation or service received. We suggest you contact the Secretary of State, or other appropriate agency, for more information.

2711 Centerville Road Wilmington, DE 19808
(888) 690-2882 | sop@cscinfo.com

EXHIBIT G

Valley Forge Life
Insurance Company

October 30, 2005

L. Scott Keehn, Esq.
Robbins Keehn
530 "B" Street, Suite 2400
San Diego, CA 92101

In re: Francis J. Lopez

Dear Mr. Keehn:

Pursuant to Subpoena in a Case Under the Bankruptcy Code, please find enclosed the responsive documents for the time period June 30, 2004 to the present. Mr. Lopez is insured under Term Policy No. VITU045825. The policy has no cash value, no outstanding loans and is paid until February 5, 2006.

Should you have any questions or wish to discuss the matter further, please do not hesitate to contact me at 800-888-9772, extension 6863 or directly at 248-746-6863.

Very truly yours,

S. L Garbovan

Sandra L. Garbovan
Legal Administrator

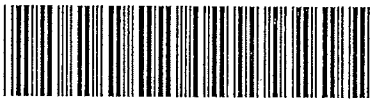
Enclosure

25800 Northwestern Highway, P O Box 600, Southfield, MI 48037-0600
Phone 1-800-888-9772 Fax (248) 746-6846

EXHIBIT H

LAST NAME

FIRST NAME



M/R UNIT #

ACCT#

BIRTHDATE

ADMIT DATE

D/C DATE

NAME: LOPEZ,FRANCIS

UNIT#: F000328170

ACCT#: F00708722055 ER F.DECC
B/DAY: 07/07/1961
SER DATE: 07/03/2004

DESTIN EMERGENCY CARE CENTER ENCOUNTER RECORD

A DEPARTMENT OF FORT WALTON BEACH MEDICAL CENTER

Patient No.	Unit No.	Service Date/Time	Age	DOB	Sex	ED Physician
F00708722055	F000328170	07/03/04 1850	42	07/07/61	M	Abelly,Andre

Patient Name: LOPEZ,FRANCIS
Allergies: NKDA,NKCA,NKFA,NKA

Reason for Visit: PAIN BACK RADIATING TO LT AND MID ABD
Temp. 102.5 Pulse 130 Resp. 18 B/P 142/94 Weight 208#

Primary Care Physician: Unknown-Do Not Use
O2 Sat: 98% ☐ RA ☐ O2

VISUAL ACUITY: OS OD OU ☐ WITH CORRECTION ☐ WITHOUT CORRECTION

TO ROOM # | Time / Initials: 1930 | ☑ Call bell within reach ☑ Pt./Family verbalizes understanding | FHT:

Mode of Arrival: POV | Accompanied By: spouse | Tetanus Hx. NA

	TIME/ INITIALS		TIME/ INITIALS		TIME/ INITIALS		TIME/ INITIALS
☑ CBC	7:20 [illegible]	☐ GYN PROFILE		☐ PCXR		☐ OLD RECORDS	
☑ BMP		☐ HCG QUAL		☐ CHEST		☐ EKG	
☑ CMP		☐ HCG QUANT		☐ ABD SERIES		☐ MONITOR	
☐ CARDIAC ENZ		☐ RH		☐ C-SPINE		☐ O2 @	
☐ AMYLASE		☐ FHT		☐ L-SPINE			
☐ LIPASE		☐ T&S		☐ CT BRAIN		☐ ABG ☐ RA ☐ O2	
☐ PT/PTT		☐ T&C ____ UNITS		☐ IVP			
☐ MAGNESIUM		☐ UR DRUG SCREEN		☐ U/S PELVIC		☐ PEAK FLOW PRE&POST	
☐ LFTS		☐ BLOOD ALCOHOL		☐ U/S GALLBLADDER			
☐ QUICK STREP		☐				☐ ALBUTEROL x	
☑ UA ☐ CCMS ☐ CATH	2020 [illegible]	☐		☐			
☐ CULTURE		☐		☐		☐ ATROVENT x	
☐ BLOOD CULTURE X____		☐		☐		☐ JET NEB	
		☐		☐			

RADIOLOGY REPORTS: TIME/INITIALS | TIME/INITIALS

TYPE OF TEST: | TYPE OF TEST:
REPORT: | REPORT:
RADIOLOGIST: | RADIOLOGIST:

VITAL SIGNS TIME	TEMP	PULSE	RESP	B/P	O2 SAT

ACCU: TIME	FSBS	INSULIN	INITIALS	RESP TREATMENTS	PEAK FLOW PRE	POST
				#1		
				#2		
				#3		

ORTHOSTATIC VITAL SIGNS	LYING	SITTING	STANDING
BP			
HR			
C/O DIZZINESS ?	☐ YES	☐ NO	TIME/INI
POSITIVE TILT ?	☐ YES	☐ NO	

MEDICATION / DOSE / ROUTE	TIME/ INITIALS	IV'S TREATMENTS, ETC	TIME/ INITIALS
2040 [illegible]		– [illegible] BP [illegible]	
– Toradol [illegible]		– Cipro 500 BID x 10 dy	
– Darvocet-N-100 ī PO, 2020 [illegible]		– Flagyl 500 QID x 10 dy	
		– Darvocet N-100 #40 ī PO q4 hrs PRN	
		– Colchicine 0.6 PO [illegible]	

INITIAL DECODING:

INITIALS	SIGNATURE
RR	[signature]
[illegible]	B. [signature]
MAD	[signature]

SEE T-SHEET

☑ DISCHARGE ☐ AMA ☐ LWBS ☐ ELOPED
TIME: 2120 DATE: 7-3-04 INITIALS: [illegible]
CONDITION ON DISCHARGE: ☑ SAME ☐ IMPROVED ☐ CHANGED
TO: ☑ HOME ☐ ADMIT TO: ____ ☐ NH ____
☐ DECEASED ☐ TRANSFER TO ____
MODE: ☑ AMBULATORY ☐ CARRIED ☐ W/C ☐ CRUTCHES ☐ STRETCHER
ACCOMPANIED BY ☑ PATIENT ☐ FAMILY / PARENTS ☐ FRIEND ☐ EMS ☐ POLICE
REC'D WRITTEN INSTRUCTIONS: ☑ YES ☐ NO
RX: GIVEN: ☑ YES ☐ NO MED DISP: ☐ YES ☑ NO
FOLLOW UP INSTRUCTIONS GIVEN: ☑ YES ☐ NO
VOICED UNDERSTANDING / DENIES FURTHER QUESTIONS ☑ YES ☐ NO

[illegible handwriting]

____ PA-C/ARNP [signature] MD / DO

C:\My Documents\ED Encounter Record.doc

83494

REV 5/2003

08

Destin Urgent Care Center
EMERGENCY PHYSICIAN RECORD
Low Back Pain / Injury

LOPEZ, FRANCIS
F00708722055 PRE ER
07/03/04 Abelly, Andre
DOB: 07/07/61 42 M MR# F000328170

DATE: 7/3/4 TIME: 1948 ROOM: 9 __EMS Arrival

HISTORIAN: (patient) __paramedic __translator __other

AGE 42 (M) / F

__History limited by

HPI chief complaint / location of injury:

(back pain) hx of chronic back pain

↑ 2 weeks + ald pain x 2 days.

duration / started: (see above)

timing
- __continues in E.D.
- __better
- __gone now
- __intermittent
- __worse

recent injury: (no) __yes __possibly

how (context)? __lifting __turning/bending __fall / near-fall __trauma

when? __as above

where occurred? __home __work __school

__Similar symptoms previously

__Recently seen/treated by doctor

☒ Agree w/ nurse's note for PFSH / ROS

ROS

☒ ROS below otherwise negative

GU
- __trouble w/ urination
- __frequent urination
- __blood in urine

OTHER
- __fever
  subjective / to ____ °F
- __chills

Women LNMP
- __vaginal bleeding
  normal period / abnormal
- __vaginal discharge
- __missed/abnormal period(s)
- __denies pregnancy

NEURO & PSYCH
- __headache
- __depression

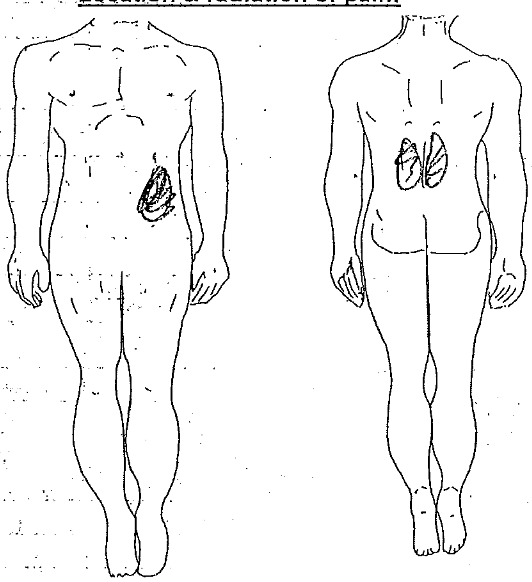
ENT, PULMONARY, CVS
- __sore throat
- __cough
- __trouble breathing
- __chest pain

GI
- __abdominal pain
- __nausea
- __vomiting
- __diarrhea
- __black/bloody stool

SKIN & MS
- __skin rash
- __neck pain

Location & radiation of pain:

(pain)
paresthesias
paresis



quality and severity of pain:
similar to prior back pain(s)
burning sharp acute
dull radiating
mild (moderate) severe

Pain Scale: (1-10)

neurologic symptoms: (crossed out)
- __~~bowel dysfunction~~
- __~~bladder dysfunction~~
- __~~radiation to leg~~
- __~~sensori-motor loss~~

Modifying Factors:

exacerbated by:
supine / upright position
(movement) (to right / to left / flexion)
cough / deep breaths / nothing
→ [illegible]

relieved by:
supine / upright position
(remaining still)
nothing

PAST HISTORY __Prior records ordered / reviewed ☐ Tetanus UTD

- __prior back injury
- __prior back pain
  episode(s) chronic
- __intervertebral disc disease
- __arthritis
- __compression fracture(s)
- __back surgery
  laminectomy fusion discectomy
- __Other [illegible] x 10

- __peptic ulcer disease
  documented? yes no
- __aortic aneurysm
- __kidney stone
- __urinary tract infectn
- __prostatitis
- __pancreatitis
- __high blood pressure
- __diabetes *insulin / oral / diet*
- __heart disease

Medications __none (see list)
__ASA __NSAID __acetaminophen

Allergies (NKDA)
__see list

SOCIAL HX __smoker __drugs
__alcohol (*recent / heavy / occasional*)
__lives alone __lives in nursing home __lives at home
__occupation

FAMILY HX

Version 2002

DESTIN EMERGENCY CARE CENTER

A Department of Fort Walton Beach Medical Center
Patient Care Record

Date: 7/3/04 **Time:** 1850 **Mode of Arrival:** (POV) EMS Ambulatory W/C Stretcher

Name: Francis **TRIAGE NURSE** Ruth Rebecca

Acuity: *(circle)* Emergent Urgent (Non-Urgent)

SUBJECTIVE

CHIEF COMPLAINT: pain middle of back to front abd area 2d ago

Date of Onset: 2wks ago Time of Onset:
Provoked by: movement
Quality of Pain: Sharp (Dull) Burning Pressure Other
Does pain Radiate: No (Yes) where around to front - side to mid abd
Severity Pain Assessment: (*circle*) N/A 7 /10 Constant Intermittent
Previous Treatment:(*circle*) None Meds Darvocet @ noon - Advil
Other water

INFANT/CHILD (12 years and under) N/A

Height/Length: _____ Inches, (as applicable) Weight: _____ # _____ Oz. _____ Kg
Head Circumference (*if < 2yrs & applicable to chief complaint*): _____ cms.
Childhood Immunizations: (*circle*) N/A UTD School Age Unknown Past Due

IS CHILD APPROPRIATE FOR DEVELOPMENTAL STAGE? YES NO

Allergies:(circle all that apply)

Drug Allergies: (None) or Yes _____ Latex Allergies: (No) or Yes
Environmental (None) or Yes _____ IV Contrast : (No) or Yes

Past Medical History (check all that apply) PNEUMOVAX Y / N FLU VAC Y / N

Previous Medical History: (Yes) No Historian: (Patient)/Spouse Parent Other:

Alcohol abuse		Cataracts/Glaucoma		GI diverticulosis		Neurologic/Seizures		Tobacco	
Anemia		CVA		GU/Renal		Orthopedic		Other	
Asthma		Diabetes		Headaches		Psychiatric			
Cancer		Known Drug Abuse		Hepatitis		Respiratory/TB			
Cardiac		ENT		Hypertension	X	Thyroid			

GYN History (N/A)

LMP _____ Gravida _____ Para _____ Pregnant Y / N ? EDC _____ FHT _____ B C: _____

Current Medications: Circle if "(See Attached List)

1) Tizac 18C daily
2)
3)
4)
5)
6)
7)
8)

Psychosocial Assessment (circle appropriate response)

EYE CONTACT: (Y) or N **AFFECT:** (Appropriate) Anxious Depressed Flat Hostile Inappropriate manic affect
IDEATIONS: (None) Harmful to self Harmful to others **SPEECH:** (Clear) Garbled Mumbled Mute Slurred
SUPPORT: Lives with spouse (family)/significant other Home health Independent
MOTOR BEHAVIOR: (Cooperative) Agitated Restless
Does patient exhibit concern regarding financial implication of health care choices? Yes (No)

Destin Emergency Care /Monitor/Treatment/Interventions

OPEZ, FRANCIS
)0708722055 PRE ER
:/03/04 Abelly,Andre
)B:07/07/61 42 M MR# F000328170
)RT WALTON BEACH MEDI

Patient Name: _____ **Date:** _____

KEY: FT = Family Taught PT = Patient Taught VU = Verbal Understanding
RD = Returned Demonstration NR = Need Reinforcement

VITAL SIGNS

TIME	BLOOD PRESSURE	PULSE RATE	RESPIRATORY RATE	TEMPERATURE	PULSE OX	INITIALS

MONITOR

CARDIAC MONITOR	N/A	NSR	SB	ST	SVT	VT	AFIB
ELB	N/A	PAC's	PJC's	PVC's			
12 Lead EKG	Time		Time		Time		

MEDICATIONS

TIME	MEDICATIONS	DOSE	ROUTE	SITE	RESPONSE	Pt Educated	Pt/Family Understand	INITIALS
2 2n	Darvocet	N 100	po			y	y	

RESPIRATORY TREATMENT

TIME	MEDICATIONS	PULSE BEFORE	PULSE DURING	PULSE AFTER	RESPONSE	Pt Educated	Pt/Family Understand	INITIALS

INTRAVENOUS

TIME ESTABLISHED	CATH GUAGE	SITE	ATTEMPTS	Pt Educated	Pt/Family Understand	INITIALS
2n 410	#20			y	y	
TIME D/C 2 12n	CATH INTACT YES/NO	APPEARANCE OF SITE		y	y	

IV FLUIDS

TIME	SOLUTION	RATE ORDERED	ADDITIVES	AMOUNT INFUSED	INITIALS

WOUND CARE

TIME	WOUND CARE	EXTREMITY DRESSING/SPLINT	ICE	ELEVATE	Pt Educated	INITIALS

MISC PROCEDURES

TIME	PROCEDURE	COMMENTS	INITIALS

Please read both sides before signing.

1. **Consent to Treatment.** I consent to the provision of medical care required to treat the condition for which I am being admitted to the Hospital, including routine diagnostic procedures and other medical treatments ordered by my physician or other healthcare professional on the Hospital's medical staff. I understand that, absent emergency or extraordinary circumstances, major medical or surgical procedures will not be performed upon me unless and until I have had an opportunity to discuss the risks and benefits of the procedure or treatment with the physician or other healthcare professional. I understand that it is the treating healthcare professional's responsibility to obtain my informed consent, and that I have the right to consent, or to refuse consent to a proposed procedure or therapeutic course after discussion with the treating healthcare professional.
   Acknowledged: _____(initial)
2. **Patient Self-Determination Act.** I have been offered information regarding Advance Directives (such as durable powers of attorney for healthcare and living wills), and have been informed that I may receive a copy of this information at any time during my hospital stay. I have been informed that a Patient Handbook containing patient rights and responsibilities and other information relating to my stay is available to me in Patient Registration or at my request during my hospital stay. **Please initial the following applicable statements:**
   I have executed an Advance Directive and have been requested to supply a copy to the Hospital. _____
   I have not executed an Advance Directive. _____
   I wish to execute an Advance Directive at this time. _____
   I do not wish to execute an Advance Directive at this time. _____
3. **Notice of Privacy Practices.** I acknowledge that I have received the Hospital's Notice of Privacy Practices, which describes the ways in which the Hospital will use and disclose my healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Hospital Privacy Official designated on the Notice if I have a complaint.
   Acknowledged: _____(Initial)
4. **Payment:** I permit the Hospital and the physicians or other health professionals involved in my inpatient or outpatient care to release the healthcare information necessary to facilitate payment by a person or entity liable for payment on my behalf to such person or entity in order to verify coverage or payment questions, or for any other purpose related to benefit payment. If I am a Medicare or Medicaid patient, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurses notes, consultations, psychological and/or psychiatric reports and discharge summary. This consent specifically includes information concerning psychological conditions, psychiatric conditions, and/or infectious diseases, including, but not limited to, blood-borne diseases such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).
   Acknowledged: _____ (Initial)
5. **Assignment of Benefits.** In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage to pay the Hospital and/or hospital-based physicians* directly for the services the Hospital and/or hospital-based physicians provide to me, my minor child, or other person entitled to health care benefits for this admission. In return for the services rendered and to be rendered by the Hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the Hospital and/or hospital-based physicians all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance polices and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the

All sections, front and back, are incorporated by reference herein.

I hereby certify that I have read and understand this Conditions of Admission and Consent for Medical Treatment Form, and I have signed this document knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

☐ Patient is medically unable to sign the Conditions of Admissions

Date: 7-3-04

Time: 2020 ☐ a.m. ☐ p.m.

Patient/Parent/Guardian/Conservator	If other than patient, indicate relationship
X	
Spouse (if married/available)	Witness (to Signature only)
X	X

Fort Walton Beach Medical Center
1000 Mar Walt Drive
Ft walton Beach, FL 32547
850-862-1111

Place Patient Identification Label or Account Number Here

Conditions of Admission and Consent for Medical Treatment

Patient	Unit #	Service/Location	Status	Account #
LOPEZ,FRANCIS	F000328170	DESTIN EMERGENCY CAR	REG ER	F00708722055

PATIENT Alternate Address? N

Soc Sec No	DOB	Age	Sex	MS	Race	Religion
551-35-1124	07/07/61	42	M	M	W	NON

Address: 310 SAND MYRTLE TRAIL
DESTIN, FL 32541
Home Phone: (850)650-8341
Language:
County: OKALOOSA COUNTY
Country: USA

PATIENT EMPLOYER
SELF EMPLOYED
.
.,XX 00000
Work Ph: (999)999-9999 Occp:

GUARANTOR
LOPEZ,FRANCIS J SS#: 551-35-1124 Rel/Pt: PATIENT
Address: 310 SAND MYRTLE TRAIL
DESTIN,FL 32541
Home Ph: (850)650-8341
County: OKALOOSA COUNTY

GUARANTOR EMPLOYER
SELF EMPLOYED
.
.,XX 00000
Work:(999)999-9999
Occp:

OTHER GUARANTOR
SS#: -- Rel/Pt:
Address:
Home Ph:
County:

OTHER GUARANTOR EMPLOYER
Work:
Occp:

PERSON TO NOTIFY
Home: Work:
Rel to Patient:

NEXT OF KIN
LOPEZ,MADELEINE
310 SAND MYRTLE TRAIL
DESTIN,FL 32541
Home:(850)650-8341 Work:
Rel to Patient: WIFE

TEMPORARY ADDRESS
Exp:
Comment:

INSURANCE #1 FC 99
SELF PAY
SELF PAY
Phone

Ins # 1 SELFPAY 00000
Policy # 551351124
Insured LOPEZ,FRANCIS
Rel to Pt PATIENT
Eff. to Rel Y Assign Y
Group 99999 - SELFPAY

AUTHORIZATION
Auth Reqd-N Auth Date:
Type: No: LOS
Auth Ph: By:
Verf Reqd-Y Verf Date:
Ver Ph: By:

INSURANCE #2
Phone

Ins # 2
Policy #
Insured
Rel to Pt
Eff. to Rel Assign
Group

AUTHORIZATION
Auth Reqd- Auth Date:
Type: No: LOS
Auth Ph: By:
Verf Reqd- Verf Date:
Ver Ph: By:

INSURANCE #3
Phone

Ins # 3
Policy #
Insured
Rel to Pt
Eff. to Rel Assign
Group

AUTHORIZATION
Auth Reqd- Auth Date:
Type: No: LOS
Auth Ph: By:
Verf Reqd- Verf Date:
Ver Ph: By:

OCCURRENCES

Code	Type	Date	Time
11	ONSET OF SYMPTOMS/ILLNESS	07/03/04	

CONDITIONS
Code Type
Adm Priority: EM
Senior Friend? N
Ins Card Copy: N
If No,reason: NASP

ACCIDENT INFO
Accident ? N
Type:
Location of Accident:
Date: Time:
Other persons involved:

Admission Comment: FS CC
Pt Valuables: NONE
Spec Prg:

PHYSICIANS

Attending Physician	Admitting Physician	Emergency Room Physician
		Abelly,Andre
Prim Care Physician	Family Physician	Other Physician

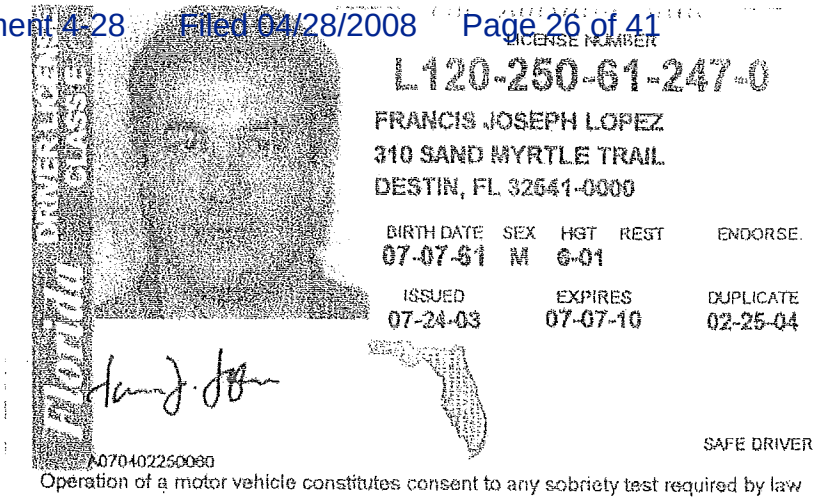
ADMISSION/REGISTRATION

Date	Time	Source	Rm/Bed	Arrival	Principal Admitting Diagnosis/Reason for Visit	Admitted By
07/03/04	2020	SELF REFERRAL	/	AUTOMOBILE	PAIN BACK RADIATING TO LT AND MID ABD	1RSVBV0730

Fort Walton Beach Medical Center
1000 Mar-Walt Drive Fort Walton Beach, FL 32547

REGISTRATION FORM A7001 Printed 07/03/04 2022

U# A#



LICENSE NUMBER
L120-250-61-247-0

FRANCIS JOSEPH LOPEZ
310 SAND MYRTLE TRAIL
DESTIN, FL 32541-0000

BIRTH DATE	SEX	HGT	REST	ENDORSE.
07-07-61	M	6-01		

ISSUED	EXPIRES	DUPLICATE
07-24-03	07-07-10	02-25-04

SAFE DRIVER

A070402250060
Operation of a motor vehicle constitutes consent to any sobriety test required by law

RUN DATE: 07/03/04 FORT WALTON BEACH MEDICAL CENTER PAGE 1
RUN TIME: 2126 CLINICAL LABORATORY
1000 MAR WALT DRIVE
FORT WALTON BEACH, FL. 32547

*** STAT BROADCAST REPORT ***

NAME: LOPEZ,FRANCIS AGE/SEX: 42/M ROOM/BED:
ACCT #: F00708722055 UNIT #: F000328170 ADM DATE:
ADM PHYSICIAN:
DIAG: PAIN BACK RADIATING TO LT AND MID ABD

Specimen: 0703:FW:U00046S Collected: 07/03/04-2040 Status: COMP Req#: 01240574
Received: 07/03/04-2040 Subm Dr: Abelly,Andre

Ordered: UA DIPSTICK

Test	Low	Normal	High	Flag	Reference	Site
		*** URINALYSIS ***				
UA DIPSTICK						
UA COLOR		YELLOW			YELLOW	DEC
UA APPEARANCE		CLEAR			CLEAR	DEC
UA GLUCOSE		NEGATIVE			NEGATIVE MG/DL	DEC
UA BILIRUBIN		NEGATIVE			NEGATIVE MG/DL	DEC
UA KETONES		NEGATIVE			NEGATIVE	DEC
UA SPEC GRAVITY		1.010			1.016-1.022	DEC
UA BLOOD		NEGATIVE			NEGATIVE	DEC
UA PH		6			5.0 - 9.0	DEC
UA PROTEIN			TRACE	*	NEGATIVE MG/DL	DEC
UA UROBILLINOGEN		NORMAL			<2.0 MG/DL	DEC
UA NITRITE		NEGATIVE			NEGATIVE	DEC
UA LK ESTERASE		NEGATIVE			NEGATIVE	DEC

DEC - DESTIN EMERGENCY CARE CENTER

PATIENT: LOPEZ,FRANCIS ROOM/BED: ACCT #: F00708722055

RUN DATE: 07/03/04
RUN TIME: 2127

FORT WALTON BEACH MEDICAL CENTER
CLINICAL LABORATORY
1000 MAR WALT DRIVE
FORT WALTON BEACH, FL. 32547

*** STAT BROADCAST REPORT ***

NAME: LOPEZ,FRANCIS AGE/SEX: 42/M ROOM/BED:
ACCT #: F00708722055 UNIT #: F000328170 ADM DATE:
ADM PHYSICIAN:
DIAG: PAIN BACK RADIATING TO LT AND MID ABD

Specimen: 0703:FW:H00131S Collected: 07/03/04-2040 Status: COMP Req#: 01240574
Received: 07/03/04-2040 Subm Dr: Abelly,Andre

Ordered: CBC

Test	Low	Normal	High	Flag	Reference	Site
*** HEMATOLOGY ***						
*** COMPLETE BLOOD COUNT ***						
CBC						
WBC			13.1	H	4.8-10.8 K/MM3	DEC
RBC		4.64			4.20-5.40 M/MM3	DEC
HGB		14.2			14.0-18.0 GM/DL	DEC
HCT		40.2			39.0-55.0 %	DEC
MCV		86.6			80.0-100.0 FL	DEC
MCH		30.6			25.0-35.0 PG	DEC
MCHC		35.3			31.0-37.0 GM/DL	DEC
RDW		12.8			11.5-14.5 %	DEC
PLT		195			130-450 K/MM3	DEC
MPV		7.8			7.4-10.4 FL	DEC
LYMPH %	10.0			L	20.5-51.1 %	DEC
MONO %		3.9			2.0-9.0 %	DEC
LYMPH #		1.3			1.2-3.4 K/MM3	DEC
MONO #		0.5			0.1-0.6 K/MM3	DEC
GRAN %			86.1	H	42.2-75.2 %	DEC
GRAN #			11.3	H	1.4-6.5 K/mm3	DEC

DEC - DESTIN EMERGENCY CARE CENTER

RUN DATE: 07/03/04
RUN TIME: 2108

FORT WALTON BEACH MEDICAL CENTER
CLINICAL LABORATORY
1000 MAR WALT DRIVE
FORT WALTON BEACH, FL. 32547

*** STAT BROADCAST REPORT ***

NAME: LOPEZ,FRANCIS AGE/SEX: 42/M ROOM/BED:
ACCT #: F00708722055 UNIT #: F000328170 ADM DATE:
ADM PHYSICIAN:
DIAG: PAIN BACK RADIATING TO LT AND MID ABD

Specimen: 0703:FW:C00241S **Collected:** 07/03/04-2040 **Status:** COMP **Req#:** 01240574
Received: 07/03/04-2040 **Subm Dr:** Abelly,Andre

Ordered: CHEM UC

Test	Low	Normal	High	Flag	Reference	Site
*** CHEMISTRY ***						
*** CHEMISTRY PROFILES ***						
CHEM UC						
NA	136			L	138-146 MMOL/L	DEC
K		3.7			3.5-4.9 MMOL/L	DEC
CL		105			98-107 MMOL/L	DEC
BUN		14			5-16 MG/DL	DEC
CREA		1.1			0.6-1.3 MG/DL	DEC
GLU		95			70-105 MG/DL	DEC

DEC - DESTIN EMERGENCY CARE CENTER

RUN DATE: 07/03/04 FORT WALTON BEACH MEDICAL CENTER PAGE 1
RUN TIME: 2108 CLINICAL LABORATORY
1000 MAR WALT DRIVE
FORT WALTON BEACH, FL. 32547

*** STAT BROADCAST REPORT ***

NAME: LOPEZ,FRANCIS AGE/SEX: 42/M ROOM/BED:
ACCT #: F00708722055 UNIT #: F000328170 ADM DATE:
ADM PHYSICIAN:
DIAG: PAIN BACK RADIATING TO LT AND MID ABD

Specimen: 0703:FW:C00241S **Collected:** 07/03/04-2040 **Status:** COMP **Req#:** 01240574
Received: 07/03/04-2040 **Subm Dr:** Abelly,Andre

Ordered: CHEM UC

Test	Low	Normal	High	Flag	Reference	Site
		*** CHEMISTRY ***				
		*** CHEMISTRY PROFILES ***				
CHEM UC						
NA	136			L	138-146 MMOL/L	DEC
K		3.7			3.5-4.9 MMOL/L	DEC
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GLU		95			70-105 MG/DL	DEC

DEC - DESTIN EMERGENCY CARE CENTER

RUN DATE: 07/03/04
RUN TIME: 2108

FORT WALTON BEACH MEDICAL CENTER
CLINICAL LABORATORY
1000 MAR WALT DRIVE
FORT WALTON BEACH, FL. 32547

PAGE 1

*** STAT BROADCAST REPORT ***

NAME: LOPEZ,FRANCIS AGE/SEX: 42/M ROOM/BED:
ACCT #: F00708722055 UNIT #: F000328170 ADM DATE:
ADM PHYSICIAN:
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Specimen: 0703:FW:C00241S Collected: 07/03/04-2040 Status: COMP Req#: 01240574
Received: 07/03/04-2040 Subm Dr: Abelly,Andre

Ordered: CHEM UC

Test	Low	Normal	High	Flag	Reference	Site
*** CHEMISTRY ***						
*** CHEMISTRY PROFILES ***						
CHEM UC						
NA	136			L	138-146 MMOL/L	DEC
K		3.7			3.5-4.9 MMOL/L	DEC
CL		105			98-107 MMOL/L	DEC
BUN		14			5-16 MG/DL	DEC
CREA		1.1			0.6-1.3 MG/DL	DEC
GLU		95			70-105 MG/DL	DEC

DEC - DESTIN EMERGENCY CARE CENTER

LAST NAME

FIRST NAME

M/R UNIT #

ACCT#

BIRTHDATE

ADMIT DATE

D/C DATE

NAME: LOPEZ,FRANCIS

UNIT#: F000328170

ACCT#: F00708756587 ER F.DECC
B/DAY: 07/07/1961
SER DATE: 07/13/2004

DESTIN EMERGENCY CARE CENTER ENCOUNTER RECORD

A DEPARTMENT OF FORT WALTON BEACH MEDICAL CENTER

Patient No.	Unit No.	Service Date/Time	Age	DOB	Sex	ED Physician
F00708756587	F000328170	07/13/04 2236	43	07/07/61	M	Abelly,Andre

Patient Name: LOPEZ,FRANCIS
Allergies: NKDA,NKCA,NKFA,NKA

Reason for Visit: RECHECK DIVERTICULITIS,NOT FEELING BETTER.
Temp. 98.3 | Pulse 79 | Resp. 20 | B/P 143/81 | Weight 205

Primary Care Physician: Unknown-Do Not Use
O2 Sat: ☐ RA ☐ O2
VISUAL ACUITY: OS | OD | OU

TO ROOM # 8 | Time / Initials 2236 / RN | ☐ Call bell within reach ☐ Pt./Family verbalizes understanding | FHT:

Mode of Arrival: Car | Accompanied By: Self | Tetanus Hx. | ☐ WITH CORRECTION ☐ WITHOUT CORRECTION

	TIME/INITIALS		TIME/INITIALS		TIME/INITIALS		TIME/INITIALS
☐ CBC		☐ GYN PROFILE		☐ PCXR		☐ OLD RECORDS	
☐ BMP		☐ HCG QUAL		☐ CHEST		☐ EKG	
☐ CMP		☐ HCG QUANT		☐ ABD SERIES		☐ MONITOR	
☐ CARDIAC ENZ		☐ RH		☐ C-SPINE		☐ O2 @	
☐ AMYLASE		☐ FHT		☐ L-SPINE			
☐ LIPASE		☐ T&S		☐ CT BRAIN		☐ ABG ☐ RA	
☐ PT/PTT		☐ T&C ___ UNITS		☐ IVP		☐ O2	
☐ MAGNESIUM		☐ UR DRUG SCREEN		☐ U/S PELVIC		☐ PEAK FLOW PRE&POST	
☐ LFT'S		☐ BLOOD ALCOHOL		☐ U/S GALLBLADDER			
☐ QUICK STREP		☐				☐ ALBUTEROL x	
☐ UA ☐ CCMS ☐ CATH		☐		☐			
☐ CULTURE		☐		☐		☐ ATROVENT x	
☐ BLOOD CULTURE X___		☐		☐		☐ JET NEB	
		☐		☐			

RADIOLOGY REPORTS: TIME/INITIALS | TIME/INITIALS
TYPE OF TEST: | TYPE OF TEST:
REPORT: | REPORT:
RADIOLOGIST: | RADIOLOGIST:

VITAL SIGNS TIME:	TEMP	PULSE	RESP	B/P	O2 SAT

ACCU√: TIME	FSBS	INSULIN	INITIALS	RESP TREATMENTS	PEAK FLOW PRE	POST
				#1		
				#2		
				#3		

ORTHOSTATIC VITAL SIGNS	LYING	SITTING	STANDING
BP			
HR			
C/O DIZZINESS?	☐ YES	☐ NO	TIME/INI
POSITIVE TILT?	☐ YES	☐ NO	

MEDICATION / DOSE / ROUTE	TIME/INITIALS

IV'S TREATMENTS, ETC	TIME/INITIALS
— Continue current Rx	
— F/U with OB or Ceu surgeon	
w/ discomfort / pain persists	

INITIAL DECODING;
INITIALS SIGNATURE

☐ SEE T-SHEET

☑ DISCHARGE ☐ AMA ☐ LWBS ☐ ELOPED
TIME: 2320 DATE: 7/13/04 INITIALS: RSP/LD
CONDITION ON DISCHARGE: ☑ SAME ☐ IMPROVED ☐ CHANGED
TO: ☑ HOME ☐ ADMIT TO: ______ ☐ NH ______
☐ DECEASED ☐ TRANSFER TO ______
MODE: ☑ AMBULATORY ☐ CARRIED ☐ W/C ☐ CRUTCHES ☐ STRETCHER
ACCOMPANIED BY ☐ PATIENT ☐ FAMILY / PARENTS ☐ FRIEND ☐ EMS ☐ POLICE
REC'D WRITTEN INSTRUCTIONS: ☐ YES ☐ NO
RX: GIVEN: ☐ YES ☐ NO MED DISP: ☐ YES ☐ NO
FOLLOW UP INSTRUCTIONS GIVEN: ☐ YES ☐ NO
VOICED UNDERSTANDING / DENIES FURTHER QUESTIONS ☐ YES ☐ NO

______ PA-C/ARNP ______ [signature] MD / DO

C:\My Documents\ED Encounter Record.doc
83494

REV 5/2003

24

Destin Urgent Care Center

EMERGENCY PHYSICIAN RECORD

General Adult

LOPEZ, FRANCIS
F00708756587 PRE ER
07/13/04 Abelly, Andre
DOB: 07/07/61 43 M MR#: F000328170

DATE: 7/13/4 TIME: ~~2330~~ 2225 ROOM: 8 __ EMS Arrival

HISTORIAN: (patient) __paramedic __translator __other_____

AGE 43 (M) / F

__History limited by _____

chief complaint: - rev on discharge instructions

all noted from 7/3/04

duration / started: - see 7/3/04

context: " "

signs / symptoms: - still has multi abd pain, fever + + +

quality: _____

location: RLQ abd pain

timing:	severity:	modifying factors:
(still present)	(mild)	(none)
(better)	__moderate	
__gone now	__severe	
__worse	Pain Scale: (1-10)	

__Similar symptoms previously_____

__Recently seen/treated by doctor_____

☒ Agree w/ nurse's note for PFSH / ROS

ROS

☒ ROS below otherwise negative

CONST.
__fever
subjective / to _____ °F
__chills

ENT
__sore throat
__nasal drainage / congestion

CHEST / CVS
__cough
sputum
__trouble breathing
__chest pain

GI
__abdominal pain
__nausea / vomiting
__diarrhea
__black / bloody stools

URINARY
__problems urinating
__frequent urination

FEMALE GENITAL
__abnormal bleeding/discharge
*LNMP*_____
postmenopausal / hysterectomy
__denies pregnancy

SKIN / Musculoskeletal
__skin rash
__back pain
__leg pain
__foot swelling

NEURO / EYES
__headache
__blackout
__lost feeling / power
in arm leg face R / L
__difficulty walking
__difficulty with speech
__double vision
__confusion

PAST HISTORY __Prior records ordered / reviewed ☒ Tetanus UTD

__neurological problems
CVA seizure disorder

__cardiac disease
heart attack (MI) angina
heart failure

__high blood pressure

__lung disease
asthma emphysema

__diabetes
insulin-dependent diet-controlled
oral hypoglycemic

__high cholesterol

__other problems

Medications __none __see list
__ASA __NSAID __acetaminophen
Flagyl
Cipro, Darvocet
Colchicine

Allergies (NKDA)
__see list

SOCIAL HX __smoker __drugs
__alcohol (*occasional / frequent / recent*)
__lives alone __lives in nursing home __lives at home
__occupation
FAMILY HX

Please read both sides before signing.

1. **Consent to Treatment.** I consent to the provision of medical care required to treat the condition for which I am being admitted to the Hospital, including routine diagnostic procedures and other medical treatments ordered by my physician or other healthcare professional on the Hospital's medical staff. I understand that, absent emergency or extraordinary circumstances, major medical or surgical procedures will not be performed upon me unless and until I have had an opportunity to discuss the risks and benefits of the procedure or treatment with the physician or other healthcare professional. I understand that it is the treating healthcare professional's responsibility to obtain my informed consent, and that I have the right to consent, or to refuse consent to a proposed procedure or therapeutic course after discussion with the treating healthcare professional.
   Acknowledged: _____ (initial)
2. **Patient Self-Determination Act.** I have been offered information regarding Advance Directives (such as durable powers of attorney for healthcare and living wills), and have been informed that I may receive a copy of this information at any time during my hospital stay. I have been informed that a Patient Handbook containing patient rights and responsibilities and other information relating to my stay is available to me in Patient Registration or at my request during my hospital stay. **Please initial the following applicable statements:**
   I have executed an Advance Directive and have been requested to supply a copy to the Hospital. _____
   I have not executed an Advance Directive. _____
   I wish to execute an Advance Directive at this time. _____
   I do not wish to execute an Advance Directive at this time. _____
3. **Notice of Privacy Practices.** I acknowledge that I have received the Hospital's Notice of Privacy Practices, which describes the ways in which the Hospital will use and disclose my healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Hospital Privacy Official designated on the Notice if I have a complaint.
   Acknowledged: _____ (Initial)
4. **Payment:** I permit the Hospital and the physicians or other health professionals involved in my inpatient or outpatient care to release the healthcare information necessary to facilitate payment by a person or entity liable for payment on my behalf to such person or entity in order to verify coverage or payment questions, or for any other purpose related to benefit payment. If I am a Medicare or Medicaid patient, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurses notes, consultations, psychological and/or psychiatric reports and discharge summary. This consent specifically includes information concerning psychological conditions, psychiatric conditions, and/or infectious diseases, including, but not limited to, blood-borne diseases such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).
   Acknowledged: _____ (Initial)
5. **Assignment of Benefits.** In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage to pay the Hospital and/or hospital-based physicians* directly for the services the Hospital and/or hospital-based physicians provide to me, my minor child, or other person entitled to health care benefits for this admission. In return for the services rendered and to be rendered by the Hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the Hospital and/or hospital-based physicians all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance polices and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the

All sections, front and back, are incorporated by reference herein.

I hereby certify that I have read and understand this Conditions of Admission and Consent for Medical Treatment Form, and I have signed this document knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

☐ Patient is medically unable to sign the Conditions of Admissions

Date: 7-13-04

Time: 23:00 ☐ a.m. ☑ p.m.

Patient/Parent/Guardian/Conservator	If other than patient, indicate relationship
X [signature]	
Spouse (if married/available)	**Witness (to Signature only)**
X	X [signature]

Fort Walton Beach Medical Center
1000 Mar Walt Drive
Ft walton Beach, FL 32547
850-862-1111

Place Patient Identification Label or Account Number Here

Conditions of Admission and Consent for Medical Treatment

Patient	Unit #	Service/Location	Status	Account #
LOPEZ,FRANCIS	F000328170	DESTIN EMERGENCY CAR	REG ER	F00708756587

PATIENT Alternate Address? N

Soc Sec No	DOB	Age	Sex	MS	Race	Religion
551-35-1124	07/07/61	43	M	M	W	NON

Address: 310 SAND MYRTLE TRAIL
DESTIN, FL 32541
Home Phone: (850)650-8341
Language:
County: OKALOOSA COUNTY
Country: USA

PATIENT EMPLOYER
SELF EMPLOYED
.
.,XX 00000
Work Ph: (999)999-9999 Occp:

GUARANTOR
LOPEZ,FRANCIS J SS#: 551-35-1124 Rel/Pt: PATIENT
Address: 310 SAND MYRTLE TRAIL
DESTIN,FL 32541
Home Ph: (850)650-8341
County: OKALOOSA COUNTY

GUARANTOR EMPLOYER
SELF EMPLOYED
.
.,XX 00000
Work:(999)999-9999
Occp:

OTHER GUARANTOR
SS#: -- Rel/Pt:
Address:
Home Ph:
County:

OTHER GUARANTOR EMPLOYER
Work:
Occp:

PERSON TO NOTIFY
Home: Work:
Rel to Patient:

NEXT OF KIN
LOPEZ,MADELEINE
310 SAND MYRTLE TRAIL
DESTIN,FL 32541
Home:(850)650-8341 Work:
Rel to Patient: WIFE

TEMPORARY ADDRESS
Exp:
Comment:

INSURANCE # 1 FC 99
SELF PAY
SELF PAY
,
Phone

Ins # 1 SELFPAY 00000
Policy # 551351124
Insured LOPEZ,FRANCIS
Rel to Pt PATIENT
Eff. to Rel Y Assign Y
Group 99999 - SELFPAY

AUTHORIZATION
Auth Reqd-N Auth Date:
Type: No: LOS
Auth Ph: By:
Verf Reqd-Y Verf Date:
Ver Ph: By:

INSURANCE # 2
Phone

Ins # 2
Policy #
Insured
Rel to Pt
Eff. to Rel Assign
Group

AUTHORIZATION
Auth Reqd- Auth Date:
Type: No: LOS
Auth Ph: By:
Verf Reqd- Verf Date:
Ver Ph: By:

INSURANCE # 3
Phone

Ins # 3
Policy #
Insured
Rel to Pt
Eff. to Rel Assign
Group

AUTHORIZATION
Auth Reqd- Auth Date:
Type: No: LOS
Auth Ph: By:
Verf Reqd- Verf Date:
Ver Ph: By:

OCCURRENCES

Code	Type	Date	Time
11	ONSET OF SYMPTOMS/ILLNESS	07/13/04	

CONDITIONS
Code Type
Adm Priority: EM
Senior Friend? N
Ins Card Copy: N
If No,reason: NASP

ACCIDENT INFO
Accident ? N
Type:
Location of Accident:
Date: Time:
Other persons involved:

Admission Comment: FS ID COPIED MEVSNET RUN
Pt Valuables: NONE
Spec Prg:

PHYSICIANS
Attending Physician
Admitting Physician
Emergency Room Physician
Abelly,Andre
Prim Care Physician
Family Physician
Other Physician

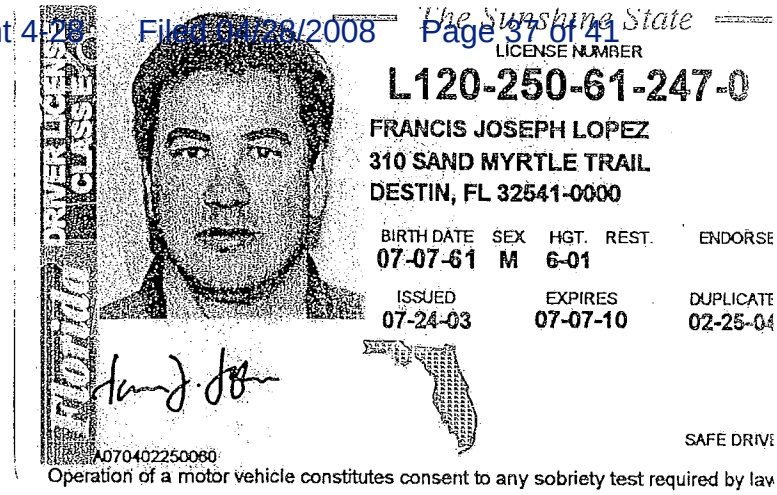
ADMISSION/REGISTRATION

Date	Time	Source	Rm/Bed	Arrival	Principal Admitting Diagnosis/Reason for Visit	Admitted By
07/13/04	2300	SELF REFERRAL	/	AUTOMOBILE	RECHECK DIVERTICULITIS,NOT FEELING BETTER.	1RSVBV0730

Fort Walton Beach Medical Center
1000 Mar-Walt Drive Fort Walton Beach, FL 32547

REGISTRATION FORM A7001 Printed 07/13/04 2322

U# A#


The Sunshine State
DRIVER LICENSE
LICENSE NUMBER
L120-250-61-247-0
FRANCIS JOSEPH LOPEZ
310 SAND MYRTLE TRAIL
DESTIN, FL 32541-0000
BIRTH DATE SEX HGT. REST. ENDORSE
07-07-61 M 6-01
ISSUED EXPIRES DUPLICATE
07-24-03 07-07-10 02-25-04
A070402250060
SAFE DRIVE
Operation of a motor vehicle constitutes consent to any sobriety test required by law

Destin Emergency Care Center After Care Instructions

A Department of Fort Walton Beach Medical Center

Patient Name: Lopez, Francis

NOTE: The examination and treatment you have received is not intended to be a substitute for or an effort to provide complete medical care. Often additional treatment is necessary and should be provided by your family doctor or the physician to whom you have been referred. (A copy of your records and test reports will be sent to the physician upon his/her request.) Report to the physician any new or remaining problems because it is possible that all elements of the injury or illness may not be recognized and treated in a single visit.

Meanwhile, FOLLOW THE INSTRUCTIONS BELOW as indicated for you.

WOUND/SUTURE CARE

- ☐ KEEP WOUND CLEAN AND DRY.
- ☐ WASH AROUND WOUND EDGE WITH _____ 3 TIMES A DAY.
- ☐ REPORT TO YOUR DOCTOR IF SWELLING, BRUISING, PUS, DRAINAGE, FOUL SMELL, NUMBNESS, FEVER OR DISCOLORATION DEVELOPS.
- ☐ KEEP WOUND COVERED WITH STERILE BANDAGE.
- ☐ IF DRESSING NEEDS TO BE CHANGED, YOU SHOULD:
  - ☐ REAPPLY STERILE DRESSING.
  - ☐ REPORT TO YOUR DOCTOR WITHIN 2 DAYS.
- ☐ STITCHES/STERI STRIPS COME OUT IN ____ DAYS.

SPRAIN, FRACTURE AND BRUISE CARE

- ☐ APPLY ICE PACK EVERY 3 HRS. FOR 15 MINS. DURING FIRST 24 HOURS.
- ☐ APPLY HEAT EVERY 4 HRS. FOR 15 MIN. AFTER 24 HRS. OF ICE.
- ☐ KEEP INJURED PART ELEVATED AND AT REST.
- ☐ KEEP CAST CLEAN AND DRY.
- ☐ MOVE FINGERS/TOES EVERY HOUR WHILE AWAKE.
- ☐ REPORT TO YOUR DOCTOR IMMEDIATELY IF SWELLING, BRUISING, PUS, FOUL SMELL, NUMBNESS, FEVER OR DISCOLORATION DEVELOPS.
- ☐ YOU MAY WALK ON THE CAST AFTER _____ HRS.
- ☐ USE CRUTCHES FOR _____ DAYS.
- ☐ ACE WRAP FOR _____ DAYS OR UNTIL PAIN FREE. REWRAP IF TOO TIGHT OR TOO CLOSE.
- ☐ GAIT TRAINING GIVEN AND PERFORMED.
- ☐ WEAR SLING/SPLINT FOR _____ DAYS.

HEAD INJURY CARE

- ☐ REST FOR _____ HRS.
- ☐ TAKE ONLY LIQUIDS FOR _____ HRS.
- ☐ WEAR CERVICAL COLLAR FOR _____ DAYS.
- ☐ REPORT TO YOUR DOCTOR IMMEDIATELY IF ANY OF THE FOLLOWING OCCUR:
  - Persistent headaches
  - Bleeding or clear fluid drains from nose or ears
  - Blurred or double vision
  - Black areas of eyes become irregular
  - Weakness in arms/legs
  - Persistent vomiting
  - Confusion, irritability or unusual drowsiness (If sleeping, wake up every 2 hrs. for 24 hrs.)

EYE, EAR, NOSE AND THROAT CARE

- ☐ REST FOR _____ DAYS.
- ☐ DO NOT PUT OBJECTS INTO YOUR EARS.
- ☐ WEAR EYE PATCH FOR _____ HRS.
- ☐ DO NOT DRIVE WHILE WEARING EYE PATCH.
- ☐ AVOID BRIGHT LIGHTS/T.V. FOR _____ HRS.
- ☐ APPLY COOL COMPRESS.
- ☐ DO NOT BLOW YOUR NOSE.
- ☐ REPORT TO YOUR DOCTOR IMMEDIATELY IF BLEEDING OCCURS THROUGH PACKING.
- ☐ USE ICE PACK TO BRIDGE OF NOSE.
- ☐ FUTURE BLEEDING MAY BE STOPPED BY PINCHING NOSTRILS TOGETHER FOR A FULL 10 MINS. AND APPLYING ICE PACKS.
- ☐ WARM SALTWATER GARGLES AS DESIRED.
- ☐ SOFT FOODS FOR _____ DAYS.
- ☐ REPORT TO YOUR DOCTOR IF FEVER GREATER THAN 100.6 DEVELOPS

MEDICAL CARE

- ☐ DRINK PLENTY OF LIQUIDS.
- ☐ CLEAR LIQUIDS FOR _____ HRS
- ☐ NO SOLID FOOD FOR _____ HRS
- ☐ NO FRIED, FATTY, SPICY FOODS.
- ☐ NO ALCOHOL.
- ☐ NO CAFFEINE.
- ☐ DIET INSTRUCTIONS GIVED: (_____ DIET)
- ☐ EAT BEDTIME SNACK.
- ☐ THREE FULL MEALS EVERY DAY.
- ☐ REST FOR _____ DAYS.
- ☐ TAKE _____ ASPIRIN/TYLENOL EVERY _____ HRS.
- ☐ WARM SOAKS/HEATING PAD EVERY _____ HRS. FOR _____ MINS.
- ☐ COLD COMPRESSES/ICE PACKS EVERY _____ HRS. FOR _____ MINS.
- ☐ REDUCE/STOP SMOKING.
- ☐ REPORT TO YOUR DOCTOR IF FEVER GREATER THAN 100.6 DEVELOPS OR PAIN WORSENS.

MEDICATIONS

- ☐ YOU HAVE BEEN GIVEN PRESCRIPTIONS FOR:
  - ☐ PAIN _____
  - ☐ INFECTION _____
  - ☐ OTHER(S) _____
- ☐ FOLLOW LABEL DIRECTIONS FOR PRESCRIPTIONS
- ☐ TAKE WITH FOOD OR MILK.
- ☐ TAKE ON AN EMPTY STOMACH.
- ☐ DO NOT DRINK ALCOHOL WHILE TAKING MEDICATIONS.
- ☐ MEDICATION MAY CAUSE DROWSINESS; DO NOT DRIVE OR OPERATE MACHINERY WHILE TAKING IT.

IMMUNIZATIONS

☐ DPT ☐ DT ☐ Tetanus Toxoid

1. If this was your first such dose of Tetanus Toxoid, you must have 2 more injections to complete this series. No. 2 should be given in 4 to 6 weeks and No. 3 should be given 6 to 12 months after No. 2. After that you should have a booster dose every 5 years if no injury requiring a booster intervenes.
2. If this was a booster dose, you will not need another booster for 5 years.

ADDITIONAL INSTRUCTIONS

Continue current medications

Follow up with GI or Dental surgeon if discomfort or pain persist

Return if needed

All X-Rays are reviewed by a radiologist. You will be notified if their interpretations differ from the interpretations of the physician who treated you. Please provide a number where you can be reached:

WORK/SCHOOL STATEMENT

- ☐ Able to work/go to school/resume previous activities.
- ☐ Limit activity for _____ days.
- ☐ Able to return to work/attend school on ____/____/____

FOLLOW-UP APPOINTMENTS

- ☐ Call your family doctor for a follow-up appointment. (Your doctor may wish to see the x-rays made while you were in the Destin Urgent Care Center. Please inquire about this when making your appointment.)
- ☐ Referred to: _____
- ☐ _____

I acknowledge that I have been informed of and understand all of the instructions given to me and have received a copy thereof. I have been instructed to contact a physician as soon as possible for continued medical diagnosis and care if indicated. I do not have any more questions at this time, but understand that I may call the **Destin Urgent Care Center** at any time should I have any further questions or need assistance in obtaining follow-up care. **Phone: (850) 837-9194**

X _____ 7/13/04 2320

Signature of Patient (or Authorized Representative) | Date | Time

Nurse Signature: Ruth Davis, RN

853029 **WHITE COPY: MEDICAL RECORDS** **YELLOW COPY: PATIENT** FCA1 5/99

DECLARATION OF DR. ABELLY

The undersigned states and declare as follows:

1. That I am a physician duly licensed to practice and practicing in the State of Florida and was the treating physician for Francis Lopez . I state such facts from my personal knowledge and if called upon to testify could so competently testify thereto.

2. That I am employed at the emergency room at Ft. Walton BeachMedical Center in Destin, FL. That on July 3, 2004 Francis Lopez came into the emergency room complaining of severe abdominal pain accompanied by a fever. I attended to him and diagnosed Mr. Lopez with a case of ~~Divirticulosis~~ Diverticulitis, which is an infection and inflammation of the large intestine.

3. That I prescribed Cipro, Darvocet and Flagyll to stop the infection and for pain relief. The side effects of these drugs may include nausea and dizziness. While on this regimen Mr. Lopez is not able to sustain his ordinary workload and must not be subject to stressful situations. Forcing Mr. Lopez to travel to California and undergo the stress of preparing for and testifying at trial might be injurious to his health. It would not be in accord with good medical advice and could result in an aggravation of his condition and another hospital visit.

4. Mr. Lopez should be reevaluated in the next few weeks, and if his condition has not improved he may require further medical treatment and/or hospitalization.

5. At this time he may be unable to assist his attorney in trial preparation due to his condition. I declare under the penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on July 13, 2004 at ~~Fort Walton~~ Destin, Florida.

Andre Abelly, M.D.

copy for opposing counsel

EXHIBIT I

FROM : FAX NO. :850 269 1034 Jun. 16 2004 05:14PM P2
JUN-16-04 WED 08:32 AM 0000000 FAX NO. 0000000000 P. 02

PROMISSORY NOTE

$15,000.00

Nashville, Tennessee

June 16, 2004

FOR VALUE RECEIVED, the undersigned hereby promises to pay to the order of Wayne M. Wise the principal sum of fifteen thousand Dollars ($15,000.00), on the following terms: on sale or refinance of maker's residence on 310 Sand Myrtle Trail, Destin, FL or not later than one year from date hereof, whichever occurs earlier, with interest at the rate of six percent (6%) per annum.

In the event this note is placed in the hands of an attorney for collection or for enforcement or protection of the security, the makers and any endorsers hereof agree to pay a reasonable attorney's fee and all court and other costs.

The makers of any endorsements hereof agree to pay reasonable attorneys fee and all court and other costs.

It is further agreed that if suit is instituted against the maker(s), that in addition to any other jurisdiction, suit may be instituted and maintained in any court of competent jurisdiction in Davidson County, Tennessee. This note, in its making and in its performance shall be governed by and subject to the laws of the State of Tennessee.

All notice of honor, demand, and protest and consents to any extensions are hereby waived. All exemptions are to be waived.

Makers:

Francis Lopez
SSN: 557-35-1124

Madeleine Lopez
310 Sand Myrtle Trail
Destin, FL 32541
telephone: 850-650-8341
mobile: 760-214-1955 mobile
fax: 850-269-1034